
Adult Trauma Emergencies: Traumatic Cardiac Arrest



Note Well: *This protocol applies to patients that are in cardiac arrest as a result of penetrating or blunt trauma. Rapid assessment, airway control, providing critical interventions as needed (needle decompression, etc) and rapid transport to a trauma center is necessary in all cases.*

I. All Provider Levels

1. Refer to the Trauma Assessment protocol.
2. Initiate CPR with BVM and 100% oxygen.
3. Initiate advanced airway management with Combi-tube.



Note Well: *EMT-I and EMT-P should use ET intubation.*

4. **Transport immediately to the closest open trauma center.**
5. Establish 1 or 2 large bore IV's of Normal Saline and titrate to a systolic blood pressure or 90 mmHg en route to the facility or on-scene if entrapped.



Note Well: *An ALS Unit must be en route or on scene.*

6. Normal Saline boluses of 500 cc to a maximum of 2,000 cc.

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II. Advanced Life Support Providers

1. Administer 1.0 mg Epinephrine 1:10,000 IVP every 3 - 5 minutes for the duration of the arrest.



Note Well: EMT-I and EMT-P should administer 2.0 mg Epinephrine 1:1,000 in 8 cc of normal saline via ET if IV access is unobtainable.



Note Well: Epinephrine is not to be administered via the Combi-tube.

2. Suspect tension pneumothorax if three of the four conditions listed below are present
 - A. Severe respiratory distress.
 - B. Tracheal deviation.
 - C. Absence of lung sounds on the affected side.
 - D. Distended jugular veins.
3. If tension pneumothorax is suspected:
 - A. Perform needle decompression at the 2nd intercostal space mid-clavicular on the affected side utilizing a large bore needle with one way valve.
 - B. Reassess patient and notify Medical Control of the response to the therapy.

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III. Transport Decision

1. Transport to the closest trauma center



IV. The Following Options are Available by Medical Control Only

1. For patients presenting in ventricular fibrillation or pulseless ventricular tachycardia consider defibrillation at 200, 300, and 360 joules.

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